APPENDIX D-MEDICARE PAYMENT POLICIES

INTRODUCTION

Medicare is the nationwide health insurance program for the aged and disabled. It consists of two parts. Part A of the program, the Hospital Insurance program, covers inpatient hospital services, up to 100 days of post-hospital skilled nursing facility services and home health visits, and hospice services. Part B, the Supplementary Medical Insurance program, covers a broad range of medical services including physician services, laboratory services, durable medical equipment, outpatient hospital services and home health visits. Part C provides managed care options for beneficiaries who are enrolled in both Parts A and B.

Medicare has established specific rules governing payment for all covered services. For example, the program pays for most acute inpatient and outpatient hospital services, skilled nursing facility services, and home health care under a prospective payment system (PPS); under PPS, a predetermined rate is paid for each unit of service adjusted for diagnosis or patient care needs. Payment for physician services, clinical laboratory services, and durable medical equipment is made on the basis of fee schedules. Certain other services are paid on the basis of reasonable costs or reasonable charges. In general, the program provides for annual updates of the payment amounts to reflect inflation and other factors. In some cases, these updates are linked to the consumer price index for all urban consumers (CPI-U) or to a provider-specific market basket (MB) index which measures the price of goods and services purchased by the provider.

There are also rules regarding the cost-sharing which must be borne by beneficiaries. For Part A, these costs are coinsurance and deductibles which are established annually. For Part B, beneficiaries are responsible for a $100 deductible and a coinsurance payment of 20 percent of the established Medicare payment amounts.

For most services there are also rules on amounts beneficiaries may be billed over and above Medicare's recognized payment amounts. Under Part A, providers agree to accept Medicare's payment as payment in full and cannot bill beneficiary's amounts in excess of the coinsurance and deductibles. Under Part B, most providers and practitioners are subject to limits on amounts they can bill beneficiaries for covered services. For example, physicians and some other practitioners may choose whether or not to accept assignment on a claim. When a physician accepts assignment, Medicare pays the physician 80 percent of the approved fee schedule amount. The physician can only bill the beneficiary the 20 percent coinsurance plus any unmet deductible. When a physician agrees to accept assignment of *all* Medicare claims in a given year, the physician is referred to as a participating physician**.** Physicians who do not agree to accept assignment on all Medicare claims in a given year are referred to as nonparticipating physicians**.** Nonparticipating physicians may or may not accept

assignment for a given service. If they do not, they may charge beneficiaries more than the fee schedule amount on nonassigned claims; for physicians, these balance billing charges are subject to certain limits. For some providers such as nurse practitioners, physician assistants, and clinical laboratories, assignment is mandatory; these providers can only bill the beneficiary the 20 percent coinsurance and any unmet deductible. For other Part B services, such as durable medical equipment, assignment is optional; providers may bill beneficiaries for amounts above Medicare's recognized payment level and may do so without limit.

Because of its rapid growth, both in terms of aggregate dollars and as a share of the U.S. budget, the Medicare program has been a major focus of deficit reduction legislation considered by Congress in recent years. With a few exceptions, reductions in program spending have been achieved largely through reductions in payments to providers, primarily hospitals and physicians that together represent about 63 percent of total program payments. These reductions stemmed, but did not eliminate, year-to-year payment increases or overall program growth.

The Balanced Budget Act of 1997 (BBA 97, P.L. 105-33) achieved significant savings to the Medicare program by slowing the rate of growth in payments to providers and by enacting structural changes to the program. A number of health care provider groups stated that actual Medicare benefit payment reductions resulting from BBA 97 were larger than were intended, leading to facility closings and other limits on beneficiary access to care. In November 1999, Congress passed a package of funding increases to mitigate the impact of some BBA 97 provisions on providers. This measure, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), is part of a larger measure known as the Consolidated Appropriations Act for 2000 (P.L. 106-113). Further adjustments were made by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA), part of the larger Consolidated Appropriations Act, 2001 (P.L. 106-554). In addition to increasing Medicare payment rates, the subsequent legislation mandated the development or refinement of PPSs for different Medicare covered services.

This report provides a guide to Medicare payment rules by type of benefit. It includes a summary of current payment policies and basic rules for updating payment amounts. It also provides the most recent update information for each type of service.

MEDICARE PAYMENT POLICIES
PART A

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
1. Inpatient Prospective Payment System (IPPS) for Short-term General Hospitals			
Operating PPS For Inpatient Services Provided by Short-term General Hospitals (Operating IPPS)	Medicare pays short-term general hospitals by discharge using a prospectively determined payment system. A hospital's payment for its operating costs is calculated using a national standardized amount, which generally is higher for hospitals in large urban areas than for other hospitals, adjusted by a wage index associated with the area where the hospital is located or where the hospital has been reclassified. Payment also depends on the relative resource use associated with the diagnosis related group (DRG) to which the patient is assigned. Additional payments are made for: cases with extraordinary costs	These IPPS payment rates are increased annually by an update factor that is determined, in part, by the projected increase in the hospital market basket (MB) index. This is a fixed price index that measures the change in the costs of goods and services purchased by hospitals to create one unit of output. The update for operating IPPS is established by statute. Typically, hospitals receive less than the MB index for an update (sometimes referred to as a "diet COLA"). For example, as an update for FY2003, hospitals received the MB minus 0.55 percentage points. For FY2004, absent Congressional action, hospitals will receive a full MB increase as their update.	For FY2003, hospitals received a 2.95 percent update (the MB of 3.5 percent minus 0.55 percentage points). Also, rural and small urban hospitals received a temporary 1.6 percent payment increase for Medicare discharges from April 1, 2003 to September 30, 2003, because the Consolidated Appropriations Act of 2003 (PL.108-7) established that all hospitals would be paid on the basis of the large urban area amount during that time period. This temporary increase was further extended to discharges through March 31, 2004 by P.L. 108-89. The scheduled update for FY2004 is a 3.4 percent increase, the projected increase of the MB

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
	(outliers); indirect medical education (IME) costs (see below); and for hospitals serving a disproportionate share (DSH) of low-income patients (see below). IME and DSH payments are made through an adjustment within IPPS that results in additional monies being paid for each Medicare discharge. Additional payments may be made for cases that involve qualified new technologies that have been approved for special add-on payments. Hospitals in Hawaii and Alaska receive a cost-of-living adjustment (COLA). Certain services are reimbursed on a cost basis outside of IPPS.		when the final regulation was published on August 1, 2003.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
Capital IPPS for Short-term General Hospitals (Capital IPPS).	Medicare's capital IPPS is structured similarly to its operating IPPS for short-term general hospitals. A hospital's capital payment is based on a prospectively determined Federal payment rate, which is 3 percent higher for hospitals in large urban areas than for hospitals in other areas, depends on the DRG to which the patient is assigned, and is adjusted by a hospital's geographic adjustment factor (which is calculated from the hospital's wage index data). Capital IPPS includes an IME and DSH adjustment (see below). Additional payments are made for outliers (cases with significantly higher costs above a certain threshold). Certain hospitals may qualify for additional payments under an exceptions process. A new hospital is paid 85 percent of its allowable Medicare inpatient hospital capital-related costs for its first 2 years of operation.	Updates to the capital IPPS are not established in statute. Capital rates are updated annually by the Centers for Medicare & Medicaid Services (CMS) according to a framework which considers changes in the prices associated with capital-related costs as measured by the capital input price index (CIPI) and other policy factors, including changes in case mix intensity, errors in previous CIPI forecasts, DRG recalibration, and DRG reclassification. Other adjustments include those that implement budget neutrality with respect to outlier payments, changes in the geographic adjustment factor, and exception payments.	For FY2003, the capital IPPS update is 1.1 percent of which 0.7 percent is attributed to an increase in the forecast of the CIPI. The scheduled capital IPPS update for FY2004 is 0.7 percent, all of which is attributed the current forecast of the CIPI available when the final rule was published; other adjustments included in the capital update framework cancelled each other out.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
Disproportionate Share Hospital Adjustment	Approximately 2,800 hospitals receive the additional payments for each Medicare discharge based on a formula which incorporates the number of patient days provided to low-income Medicare beneficiaries (those who receive Supplemental Security Income (SSI)) and Medicaid recipients. A few urban hospitals, known as "Pickle Hospitals, receive DSH payments under an alternative formula that considers the proportion of a hospital's patient care revenues that are received from state and local indigent care funds. The percentage add-on for which a hospital will qualify varies according to the hospital's bed size or urban or rural location. Certain hospitals, such as sole community hospitals (SCHs, see below) and rural referral centers (RRC, see below) may qualify for special DSH treatment.	No specific update. The amount of DSH spending in any year is open-ended and varies by number of Medicare discharges as well as the type of patient seen in any given hospital.	In its March 2003 baseline, CBO estimates DSH spending (in both operating and capital IPPS) at $6.3 billion in FY2003 and $6.5 billion in FY2004.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
Indirect Medical Education (IME Adjustment)	The indirect medical education (IME) is one of two tupes of payments to teaching hospitals for graduate medical education (GME) costs (see also direct GME below). Medicare increases both its operating and capital IPPS payments to teaching hospitals to account for the additional cost associated with operating an approved GME program. Different Measures of teaching intensity are used in the operating an capital IPPS. For both IPPS payments, however, the number of medical residents who can be counted for the IME adjustment is capped, based on the bymber of medical residents as of December 31, 1996. As established by BBA 97, teaching hospitals receive IME payments for their Medicare Choice discharges.	The IME adjustment is not subject to an annual update. BBA 97 reduced the IME adjustment in operating IPPS from a 7.7 percent increase for each 10 percent increase in a hospital's ratio of interns to beds (IRB), a measure of teaching intensity in operating IPPS. There decreases were delayed by subsequent legislation. The IME operating adjustment is now 5.5 percent for every 10 percent increase in a hospital's IRB.	No specific update. The amount spent on IME depends in part on the number of Medicare discharges in teaching hospitals in any given year. CBO estimates the IME payments (for both capital and operating IPPS) to be about $6.1 billion in FY2003 and $6.3 billion in FY2004.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
Direct Graduate Medical Education Payments	Direct GME costs are excluded from IPPS and paid outside of the DRG payment on the basis of updated hospital-specific costs per resident amount (PRA), the number of weighted full-time equivalent (FTE) residents, and Medicare's share of total patient days in the hospital (including those days attributed to Medicare Choice enrollees). There is a hospital-specific cap on the number of residents in the hospital for direct GME payments. Also, the hospital's FTE count is based on a 3-year rolling average; a specific resident may count as half of a FTE, depending on the number of years spent as a resident and the length of the initial training associated with the specialty. Certain combined primary care residency programs receive special recognition in this count. Depending upon the circumstances, direct GME payments can be made to non-hospital providers.	In general, direct GME payments are updated by the increase in the consumer price index for all urban consumers (CPI-U). As established by BBRA and subsequently amended, however, the update amount that any hospital receives depends upon the relationship of its PRA to the national average PRA. Hospitals with PRAs below the floor (85 percent of the locality-adjusted, updated, and weighted national PRA) are raised to the floor amount. Teaching hospitals with PRAs above the ceiling amount (140 percent of the national average, adjusted for geographic location) will receive a lower update than other hospitals (CPI-U minus two percentage points) for FY2003- FY2005. Hospitals that have PRAs between the floor and ceiling receive the CPI-U.	The CPI-U increase to each hospital's PRA would depend upon the hospital's cost reporting period (as well as the relationship of its PRA to the national average PRA). Hospitals with cost reporting periods starting October 1 that would be eligible for the full CPI-U update to their PRA are projected to receive a 1.0179 percent increase for FY2004; those hospitals above 140 percent of the locality-adjusted weighted national PRA are projected to receive a 1.0177 percent increase in their PRA.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
2. Hospitals Receiving Special Consideration Under Medicare's IPPS			
Sole Community Hospitals--(SCHs) facilities located in geographically isolated areas and deemed to be the sole provider of inpatient acute care hospital services in a geographic area based on distance, travel time, severe weather conditions, and/or market share as established by specific criteria set forth in regulation (42 CFR 412.92).	An SCH receives the higher of the following payment rates as the basis of reimbursement: the current IPPS base payment rate, or its hospital-specific per-discharge costs from either FY 1982, 1987, or 1996, updated to the current year. The FY1996 base year option became effective for discharges on or after FY2001 on a phased-in basis and will be fully implemented for SCH discharges on or after FY2004 An SCH may receive additional payments if the hospital experiences a decrease of more than 5 percent in its total inpatient cases due to circumstances beyond its control. A rural SCH not paid on the basis of its hospital-specific costs that qualifies for DSH payments will receive a 10 percent payment increase rather than the maximum 5.25 percent DSH adjustment received by other rural	Target amounts for SCHs are updated by an “applicable percentage increase,” which is specified by statute and is often comparable to the IPPS update. .	For FY2003, hospitals received a 2.95 percent update (the MB of 3.5 percent minus 0.55 percentage points). The scheduled update for FY2004 is a 3.4 percent increase, the current forecast of the estimated MB increase available when the final rule was published. These updates are used to increase the hospital-specific rate applicable to an SCH.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
	hospitals. An SCH receives special consideration for reclassification into a different area.		
Medicare Dependent Hospitals (MDHs)--small rural hospitals with a high proportion of patients who are Medicare beneficiaries (have at least 60 percent of acute inpatient days or discharges attributable to Medicare in FY1987 or in two of the three most recently audited cost reporting periods). As specified in regulation (42 CFR 412.108), they cannot be an SCH and must have 100 or fewer beds.	BBA 1997 reinstated and extended the MDH classification, starting on October 1, 1997 to October 1, 2001. The sunset date for the MDH classification was subsequently extended to September 30, 2006 by BBRA. During that time period, an MDH is paid 50 percent of the amount that the Federal rate is exceeded by the hospital's target amount based on either its updated FY1982 or FY1987 costs. An MDH may receive additional payments if its total number of inpatient cases decreases more than 5 percent due to circumstances beyond its control.	Target amounts for SCHs are updated by an "applicable percentage increase," which is specified by statute and is often comparable to the IPPS update. .	For FY1996 and thereafter, the update for MDHs is the same as for all IPPS hospitals. These updates are used to increase the hospital-specific rate applicable to an MDH. For FY2003, hospitals received a 2.95 percent update (the MB of 3.5 percent minus 0.55 percentage points). The scheduled update for FY2004 is a 3.4 percent increase, the current forecast of the estimated MB increase.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
Rural Referral Centers (RRCs)--relatively large hospitals, generally in rural areas, that provide a broad array of services and treat patients from a wide geographic areas as established by specific criteria set forth in regulation (42 CFR 412.96).	RRCs payments are based on the IPPS for short-term general hospitals. Qualifying RRCs receive a higher DSH adjustment than do other rural hospitals. Also, RRCs receive preferential consideration for reclassification to a different area.	RRCs receive the operating and capital IPPS updates specified for short-term general hospitals.	See updates specified for operating and capital IPPS for short-term general hospitals.
3. Specialty Hospitals and Distinct Part Units			
Inpatient Rehabilitation Facilities (IRFs)--freestanding hospitals and hospital- based distinct part units with at least 75 percent of its inpatient population requiring intensive rehabilitation services for one of 10 conditions including stroke, spinal cord injury, brain injury and polyarthritis.	As of January 1, 2002, Medicare's payments to a rehabilitation facility are based on a fully implemented IRF-PPS and 100 percent of the Federal rate (also called the budget neutral conversion factor), which is a fixed amount per discharge. This PPS encompasses both capital and operating payments to IRFs, but does not cover the costs of approved educational programs, bad debt expenses, or blood clotting factors, which are paid for separately. The IRF-PPS payment for any Medicare discharge will vary depending on the patient's	The IRF-PPS update is based on the MB for excluded hospitals (those not paid under IPPS). This MB is based on cost report data from Medicare participating inpatient rehabilitation and psychiatric facilities as well as long-term, children's, and cancer hospitals, which were subject to the payment limitations and incentives established in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). The TEFRA MB only includes operating costs, so the IRF-PPS update is based on a modified TEFRA	For FY2003, the update to the IRF federal rate was 3 percent. The update for FY2004 is 3.2 percent.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
	impairment level, functional status, comorbidity conditions, and age. These factors determine which of the 380 Case Mix Groups (CMGs) is assigned to the inpatient stay. Five other CMGs are used for patients discharged before the fourth day (short stay outliers) and for those who die in the facility. Generally, IRF payments are reduced or increased for certain case level adjustments, such as early transfers, short-stay outliers, patients who die before transfer, and high cost outliers. Payments also depend upon facility-specific adjustments to accommodate variations in area wages, percentage of low-income patients (LIP) served by the hospital (a DSH adjustment), and rural location (rural IRFs receive increased payments, about 19 percent more than urban IRFs.) No IME adjustment is included; IRFs in Alaska and Hawaii do not receive a COLA adjustment.The IRF-PPS is not required to be budget neutral; total payments can exceed the amount that would have been paid if this PPS had not been implemented.	MB that reflects capital costs as well. CMS revised and rebased the excluded hospitals with capital MB to a 1997 base year (to incorporate 1997 cost report data) starting in FY2004.	

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
Long-term Care Hospitals and Satellite or Onsite Providers (LTCHs)--short- term general hospitals that are excluded from IPPS with a Medicare inpatient average length of stay (ALOS) greater than 25 days or an ALOS for all patients of greater than 20 days, among other requirements. The ALOS criteria applied to a LTCH depends upon when it was excluded from IPPS.	Effective October 1, 2002, LTCHs are paid under a DRG-based PPS, subject to a 5-year transition period. A LTCH may opt to be paid based on 100 percent of the Federal prospective rate. A new LTCH must be paid on 100 percent of the Federal rate. The LTCH-PPS encompasses payments for both operating and capital-related costs of inpatient care but does not cover the costs of approved educational programs, bad debt expenses, or blood clotting factors which are paid for separately. The LTCH-PPS payment for any Medicare discharge will vary depending on the patient's assignment into one of 510 LTCH-DRGs, which are based on reweighted IPPS DRGs. Payments for specific patients may be increased or reduced because of case-level adjustments such as short stay outliers, interrupted stays, cases discharged and	The LTCH-PPS update is based upon the modified TEFRA MB (that reflects capital costs) described previously, but the Medicare update for these providers incorporates a budget neutrality factor as well. The TEFRA MB is used to update the target amounts for those LTCHs that do not elect payments based on the fully implemented LTCH-PPS during the 5-year transition period. CMS has changed the effective date of the annual update from October 1 to July 1 of each year, starting July 2003. During the 5-year transition period, CMS calculates a budget neutrality offset to account for the ability of LTCHs to elect payment based on the transition blend methodology or on 100 percent of the Federal payment amount, whichever results in greater Medicare payments. CMS estimated that the election option to be paid 100 percent of the FEDERAL rate would cost $50 million more than	For FY2003, LTCHs that are paid on a blended rate based on 20 percent of the Federal rate and 80 percent of the TEFRA target amount had their TEFRA target amount increased by 3.5 percent, the increase in the modified TEFRA MB. The increase to the LTCH Federal rate for discharges starting in July 1, 2003, is 2.2 percent. The increase is calculated based on estimates of a 3.3 percent modified TEFRA MB decreased by 0.8 percent to accommodate the proposed change in the update cycle and then reduced by a 0.3 percent budget neutrality factor (3.3-0.8-0.3=2.2).

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
	readmitted to onsite providers (a within-hospital transfer), and high cost outliers. Payments also depend upon facility-specific adjustments to accommodate variations in area wages (implemented over a 5-year transition period) and include a COLA for hospitals in Alaska and Hawaii. No adjustments are made for the percentage of low-income patients served by the hospital (DSH), rural location, or IME. The LTCH-PPS is required to be budget neutral; total payments must equal the amount that would have been paid if PPS had not been implemented.	under the prior system in FY2003 and applied a 6.6 percent reduction to all LTCH payments. CMS reduced LTCH payments by 5.7 percent for all discharges occurring on or after July 1, 2003, and through June 30, 2004, to account for the estimated election cost of $120 million in the FY2004 rate year.	
Psychiatric Hospitals and Distinct Part Units--include those primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services for the diagnosis and treatment of people with mental illness	Psychiatric hospitals are paid on a reasonable cost basis, subject to TEFRA payment limitations and incentives. However, BBRA directed the Secretary to develop a budget neutral per-diem-based PPS for inpatient psychiatric services	Under TEFRA, an update factor for reimbursement of operating costs is established by statute and is generally pegged to the TEFRA MB described above. The amount of increase received by any specific hospital will depend upon the relationship of the	The FY2003 update is 3.5 percent. The FY2004 update is 3.5 percent.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
	and submit a report to Congress describing the proposed PPS. The required report was submitted in August 2002; proposed regulations implementing the PPS are expected shortly.	hospital's costs to its target amount. There is no specific update for capital costs, which are reimbursed on a reasonable cost basis.	
Children's and Cancer Hospitals *Children's hospitals* are those engaged in furnishing services to inpatients who are predominantly individuals under the age of 18. *Cancer hospitals* generally are recognized by the National Cancer Institute as either a comprehensive or clinical cancer research center; are primarily organized for the treatment of and research on cancer (not as a subunit of a acute general hospital or university-based medical center); and at least 50 percent of the discharges have a diagnosis of neoplastic disease. Other criteria and exceptions are	Children's and cancer hospitals are paid on a reasonable cost basis, subject to TEFRA payment limitations and incentives. Each provider's reimbursement is subject to a ceiling or target amount that serves as an upper limit on operating costs. Depending upon the relationship of the hospital's actual costs to its target amount, these hospitals may receive relief or bonus payments as well as additional bonus payments for continuous improvement; i.e., facilities whose costs have been consistently less than their limits may receive additional money. Newly established hospitals receive special treatment.	An update factor for reimbursement of operating costs is established by statute and is generally pegged to the TEFRA MB described above. The amount of increase received by any specific hospital will depend upon the relationship of the hospital's costs to its target amount. There is no specific update for capital costs. The hospital is paid 100 percent of its reasonable costs, which was subject to a 15 percent reduction through FY2002.	The FY2003 update is 3.5 percent. The update for FY2004 is 3.5 percent.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
established in statute and implemented in 42 CFR 412.23(f).	Providers that can demonstrate that there has been a significant change in services and/or patients may receive exceptions payments. The capital costs for these hospitals are reimbursed on a reasonable cost basis.		
Critical Access Hospitals (CAHs)--limited-service facilities located more than 35 miles from another hospital (15 miles in certain circumstances) or designated by the state as a necessary provider of health care; offer 24-hour emergency care; have no more than 15 acute care inpatient beds and up to 10 additional swing beds; and have a 96-hour average length of stay.	Medicare pays CAHs on the basis of the reasonable costs of the facility for inpatient and outpatient services. CAHs may elect either a cost-based hospital outpatient service payment or an all-inclusive rate, which is equal to a reasonable cost payment for facility services plus 115 percent of the fee schedule payment for professional services. Ambulance services that are owned and operated by CAHs are reimbursed on a reasonable cost basis if these ambulance services are 35 miles from another ambulance system.	No specific update policy.	No specific update policy.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
4. Skilled Nursing Facility (SNF) Care			
SNF Care	BBA 97 changed payment for SNF care from a cost-based retrospective reimbursement system to a PPS. The PPS payments are based on a daily ("per-diem") urban or rural base payment amount that is adjusted for case mix and area wages. The Federal per diem payment covers all the services provided to the beneficiary that day including room and board, nursing, therapy, and prescription drugs. Some care costs are excluded from PPS and paid separately such as physician visits, dialysis and certain high cost prosthetics and orthotics. The case-mix adjustment to the Federal per diem rate adjusts payments for the treatment and care needs of Medicare treatment and care needs of Medicare	The urban and rural Federal per diem payment rates are increased annually by an update factor that is determined, in part, by the projected increase in the SNF market basket index. This index measures changes in the costs of goods and services purchased by SNFs. BIPA 2000 provides for the following updates: FY 2001 = MB FY 2002 = MB - 0.5 FY 2003 = MB - 0.5 FY 2004 and subsequent years = MB At the end of FY 2002, two temporary add-ons expired: a 4 percent increase in base payment rates that was in effect for FY 2001 and FY 2002 from BBRA and a 16.66 percent increase in the nursing component of the payment rates that	For FY 2004 the update 3.0 percent.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
	beneficiaries and is made using a system called resource utilization groups (RUGs). The RUGs system uses patient assessments to assign a beneficiary to one of 44 categories and to determine the payment for the beneficiary's care. Patient assessments are done at various times during a patient's stay and the RUG category a beneficiary is placed in can change with changes in the beneficiary's condition; the daily SNF PPS payment will change as well. The final adjustment to the daily payment rate is to account for variations in area wages and uses the hospital wage index. Unlike other PPSs, the SNF PPS statute does not provide for an adjustment for extraordinarily costly cases (an outlier adjustment).	that was in effect from April 1, 2002, until September 30, 2002, from BIPA. The expiration of these add-on resulted in a decrease in payments of $1.4 billion. One add-on remains in effect: a temporary increase in 26 RUGs that will continue until the Secretary of HHS implements refinements to the RUGs. This add-on increases payments about $1 billion per year. For FY 2004, the SNF Federal rate will be increased an additional 3.26 percent above the update to reflect the cumulative forecast error since the start of the SNF PPS on July 1, 1998.	

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
5. Hospice Care			
Hospice Care	Payment for hospice care is based on one of four prospectively determined rates, which correspond to four different levels of care, for each day a beneficiary is under the care of the hospice. The four rate categories are: routine home care, continuous home care, inpatient respite care, and general inpatient care. Payment rates are adjusted to reflect differences in area wage levels using the hospital wage index. Payments to a hospice are subject to an aggregate cap that is determined by multiplying the cap amount for a given year by the number of Medicare beneficiaries who receive hospice services during the year. Limited cost-sharing applies to outpatient drugs and respite.	The prospective payment rates are updated annually by the increase in the hospital market basket. The hospice cap amount is adjusted annually by the percentage change in the medical care expenditure category of the CPI-U. However, BBA 97 reduced the hospice payment update to the market basket minus 1.0 percentage point for each of FY1998 through FY2002. BBRA increased the hospice payments 0.5 percent for FY 2001 and 0.85 percent for FY 2002. This increase was not included in the base for updating the payment rate in subsequent years. BIPA increased payment rates by 5 percentage points beginning April 1, 2001, through September 30, 2001. This increase was included in the base for subsequent updates. The FY2003 update was the full hospital market basket increase.	Hospice payment rates for care furnished during FY 2004 are as follows: Routine home care--$118.08 per day; continuous home care--$689.18 full rate= 24 hours of care, or $28.72 per hour; Inpatient respite care --$122.15 per day; General inpatient care -- $525.28 per day. The hospice cap for the period November 1, 2002 through October 31, 2003 is $18,661.29 per beneficiary per year.

PART B

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
1. Physicians			
Physicians	Payments for physician's services are made on the basis of a fee schedule. The fee schedule assigns relative values to services. These relative values reflect physician work (based on time, skill, and intensity involved), practice expenses, and malpractice expenses. The relative values are adjusted for geographic variations in the costs of practicing medicine. These geographically adjusted relative values are converted into a dollar payment amount by a conversion factor. Assistants-at-surgery services are paid 16 percent of the fee schedule amount. Anesthesia services are paid under a separate fee schedule (based on base and time units) with a separate conversion factor.	The conversion factor is updated each year by a formula specified in law. The update percentage equals the Medicare Economic Index (MEI, which measures inflation) subject to an adjustment to match spending under the cumulative sustainable growth rate (SGR) system. (The SGR is linked, in part, to changes in the gross domestic product.) The adjustment sets the conversion factor so that projected spending for the year will equal allowed spending by the end of the year. In no case can the conversion factor update be more than three percentage points above nor more than seven percentage points below the MEI. Application of the SGR system led to a 5.4 percent reduction in the conversion factor in 2001. An additional 4.4 percent reduction in 2002 was slated to	The 2003 conversion factor, effective March 1, 2003, is $36.7856 (compared to $36.1992 in 2002). The 2003 anesthesia conversion factor is $17.0522 (compared to $16.6055 in 2002).

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
	Payments equal 80 percent of the fee schedule amount; patients are liable for the remaining 20 percent. Assignment is optional; balance-billing limits apply on non-assigned claims.	take effect in 2003. However, enactment of P.L.108-7 allowed for revisions in previous estimates used for the SGR calculation, thereby permitting an update for 2003 of 1.6 percent.	
2. Non-physician Practitioners			
(a) Physician Assistants	Separate payments are made for physician assistant (PA) services, when provided under the supervision of a physician, but only if no facility or other provider charge is paid. Payment is made to the employer (such as a physician). The PA may be in an independent contractor relationship with the employer. The recognized payment amount equals 85 percent of the physician fee schedule amount (or, for assistant-at-surgery services, 85 percent of the amount that would be paid to a physician serving as	See physician fee schedule.	See physician fee schedule.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
	an assistant-at-surgery). Medicare payments equal 80 percent of this amount; patients are liable for the remaining 20 percent. Assignment is mandatory for PA services.		
(b) Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs)	Separate payments are made for NP or CNS services, provided in collaboration with a physician, but only if no other facility or other provider charge is paid. The recognized payment amount equals 85 percent of the physician fee schedule amount (or, for assistant-at-surgery services, 85 percent of the amount that would be paid to a physician serving as an assistant-at-surgery). Medicare payments equal 80 percent of this amount; patients are liable for the remaining 20 percent. Assignment is mandatory.	See physician fee schedule.	See physician fee schedule.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
(c) Nurse Midwives	The recognized payment amount for certified nurse midwife services equals 65 percent of the physician fee schedule amount. Nurse midwives can be paid directly. Medicare payments equal 80 percent of this amount; patients are liable for the remaining 20 percent. Assignment is mandatory.	See physician fee schedule.	See physician fee schedule.
(d) Certified Registered Nurse Anesthetists (CRNAs)	CRNAs are paid under the same fee schedule used for anesthesiologists. Payments furnished by an anesthesia care team composed of an anesthesiologist and a CRNA are capped at 100 of the percent amount that would be paid if the anesthesiologist was practicing alone. The payments are evenly split between each practitioner. CRNAs can be paid directly. Assignment is mandatory for services provided by CRNAs. Regular Part B cost-sharing applies.	See physician fee schedule.	See physician fee schedule.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
(e) Clinical Psychologists and Clinical Social Workers	The recognized payment amount for services provided by a clinical social worker is equal to 75 percent of the physician fee schedule amount. Services in connection with the treatment of mental, psychoneurotic, and personality disorders of a patient who is not a hospital inpatient are subject to the mental health services limitation. In these cases Medicare pays 50 percent of incurred expenses and the patient is liable for the remaining 50 percent. Otherwise, regular Part B cost-sharing applies. Assignment is mandatory for services provided by clinical psychologists and clinical social workers.	See physician fee schedule.	See physician fee schedule.
(f) Outpatient Physical or Occupational Therapy Services	Payments are made under the physician fee schedule. In 1999, an annual $1,500 per beneficiary limit applied to all outpatient physical therapy services (including speech-language pathology services), except for	Updates in fee schedule payments are dependent on the update applicable under the physician fee schedule. The $1,500 limit was to be increased by the increase in the MEI beginning in 2002; however, application of the limit was suspended until September 1, 2003.	See physician fee schedule. The 2003 therapy caps are $1,590, effective September 1, 2003.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
	those furnished by a hospital outpatient department. A separate $1,500 limit applied to all outpatient occupational therapy services except for those furnished by hospital outpatient departments. A separate $1,500 limit applied to all outpatient occupational therapy services except for those furnished by hospital outpatient departments. Therapy services furnished as incident to physicians professional services were included in these limits. The $1,500 limits were to apply each year. However, no limits applied in 2000, 2001, and 2002. These limits are slated to apply again in September 2003.Regular Part B cost-sharing applies. Assignment is optional for services provided by therapists in independent practice; balance-billing limits apply for non-assigned claims. Assignment is mandatory for other therapy services.		

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
3. Clinical Diagnostic Laboratory Services			
Clinical Diagnostic Laboratory Services	Clinical lab services are paid on the basis of area wide fee schedules. The fee schedule amounts are periodically updated. There is a ceiling on payment amounts equal to 74 percent of the median of all fee schedules for the test. Assignment is mandatory. No cost-sharing is imposed.	Generally, the Secretary of HHS is required to adjust the payment amounts annually by the percentage change in the CPI, together with such other adjustments, as the Secretary deems appropriate. Updates were eliminated for 1998 - 2002.	The fee schedules were updated by 1.1 percent in 2003.
4. Preventative Services			
Pap smears; Pelvic Exams	Medicare covers screening pap smears and screening pelvic exams once every two years; annual coverage is authorized for women at high risk. Payment is based on the clinical diagnostic laboratory fee schedule. Assignment is mandatory. No cost-sharing is imposed.	See clinical laboratory fee schedule. A national minimum payment amount applies for pap smears.	See clinical laboratory fee schedule. Minimum payment for pap smears in 2003 is $14.76.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
Screening Mammograms	Coverage is authorized for an annual screening mammogram. Payment is made under the physician fee schedule. The deductible is waived; regular Part B coinsurance applies. Assignment is optional. Balance billing limits apply on non-assigned claims.	See physician fee schedule.	See physician fee schedule.
Colorectal Screening	Coverage is provided for the following procedures for the early detection of colon cancer: (1) screening fecal occult blood tests (for persons over 50, no more than annually); (2) screening flexible sigmoidoscopy (for persons over 50, no more than once every four years and 10 years after a screening colonoscopy for those not at high risk for colon cancer); (3) screening flexible colonoscopy for high-risk individuals (limited to one every two years) and for those not at high risk, every 10 years or four years after a screening sigmoidoscopy; and (4) barium enemas (as an alternative to either a screening flexible sigmoidoscopy or screening colonoscopy in accordance with the same screening parameters established for those tests).	See physician fee schedule and lab fee schedule.	See physician fee schedule and lab fee schedule.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
	Payments are based on rates paid for the same procedure when done for a diagnostic purpose. Fecal occult blood tests are paid under the lab fee schedule; other tests are paid under physician fee schedule. If a sigmoidoscopy or colonoscopy results in a biopsy or removal of a lesion, it would be classified and paid as the procedure with such biopsy or removal, rather than as a diagnostic test. Assignment is mandatory for fecal occult blood tests and no cost-sharing applies. Assignment is optional for sigmoidoscopies and colonoscopies. Regular Part B cost-sharing applies; balance billing limits apply on non-assigned claims.		
Prostate Cancer Screening	Medicare covers an annual prostate cancer-screening test. Payment is made under the physician fee schedule.	See physician fee schedule.	See physician fee schedule.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
Glaucoma Screening	Medicare covers an annual glaucoma screening for persons with diabetes, persons with a family history of glaucoma and African-Americans age 50 and over. Payment is made under the physician fee schedule.	See physician fee schedule.	See physician fee schedule.
Diabetes Outpatient Self-Management Training	Medicare covers services Medicare covers services furnished by a certified provider. Payment is made under the physician fee schedule.	See physician fee schedule.	See physician fee schedule.
Medical Nutrition Therapy Services	Coverage is authorized for certain individuals with diabetes or renal disease. Payment equals 85 percent of the amount established under the physician fee schedule for the service if it had been furnished by a physician.	See physician fee schedule.	See physician fee schedule.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
Bone Mass Measurements	Bone mass measurements are covered for certain high-risk individuals. Payments are made under the physician fee schedule. In general, services are covered if they are provided no more frequently than once every two years.	See physician fee schedule.	See physician fee schedule.
5. Telehealth			
Telehealth Services	Medicare pays for services furnished via a telecommunications system by a physician or practitioner, notwithstanding the fact that the individual providing the service is not at the same location as the beneficiary. Payment is equal to the amount that would be paid under the physician fee schedule if the service had been furnished without a telecommunications system. A facility fee is paid to the originating site (the site where the beneficiary is when the service is provided).	See physician fee schedule. The facility fee equals the amount established for the preceding year, increased by the percentage increase in the MEI.	See physician fee schedule. The 2003 facility fee is $20.60.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
6. Durable Medical Equipment (DME)			
Durable Medical Equipment	DME is paid on the basis of a fee schedule. Items are classified into five groups for purposes of determining the fee schedules and making payments: (1) inexpensive or other routinely purchased equipment (defined as items costing less than $150 or which are purchased at least 75 percent of the times; (2) items requiring frequent and substantial servicing; (3) customized items; (4) oxygen and oxygen equipment; and (5) other items referred to as capped rental items. In general, fee schedule rates are established locally and are subject to national limits. The national limits have floors and ceilings. The floor is equal to 85 percent of the weighted average of all local payment amounts and the ceiling is equal to 100 percent of the weighted average of all local payment amounts. Assignment is optional. Balance billing limits do not apply on non-assigned claims. Regular Part B cost-sharing applies.	In general, fee schedule amounts are updated annually by the CPI-U. Updates were eliminated for 1998-2000; fee schedule amounts were increased by the CPI-U for 2001, and frozen for 2002. The national payment limits for oxygen and oxygen supplies are set at 70 percent of 1997 levels, updated annually by the CPI-U.	The update for 2003 is 1.1 percent.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
7. Prosthetics and Orthotics			
Prosthetics and Orthotics	Prosthetics and orthotics are paid on the basis of a fee schedule. The fee schedule rates are established regionally and are subject to national limits. The national limits have floors and ceilings. The floor is equal to 90 percent of the weighted average of all regional payment amounts and the ceiling is equal to 120 percent of the weighted average of all regional payment amounts. Assignment is optional; balance billing limits do not apply on non-assigned claims. Regular Part B cost-sharing applies.	Fee schedule amounts are updated annually by the CPI-U.	The update for 2003 is 1.1 percent.
8. Surgical Dressings			
Surgical Dressings	Surgical dressings are paid on the basis of a fee schedule. Payment levels are computed using the same methodology as the durable medical equipment fee schedule (see above). Assignment is optional; balance billing limits do not apply to non-assigned claims. Regular Part B cost-sharing applies.	See durable medical equipment fee schedule.	The update for 2003 is 1.1 percent.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
9. Parenteral and Enteral Nutrition (PEN)			
Parenteral and Enteral Nutrition (PEN)	Parenteral and enteral nutrients, equipment, and supplies are paid on the basis of a fee schedule established in 2002. Prior to this, PEN was reimbursed on a reasonable charge basis (see below under Miscellaneous Items and Services). The fee schedule amounts are based on payment amounts made on a national basis to PEN suppliers under the reasonable charge system. Assignment is optional; balance billing limits do not apply on non-assigned claims. Regular Part B cost-sharing applies.	Fee schedule amounts are updated annually by the CPI-U.	The update for 2003 is 1.1 percent.
10. Miscellaneous Items and Services			
Miscellaneous Services	Miscellaneous items and services here refers to those services still paid on a reasonable charge basis. Included are such items as splints, casts, home dialysis supplies and equipment, therapeutic shoes, certain intraocular lenses, blood	Reimbursement rates for reasonable charge items are calculated annually. Carriers determine a supplier's customary charge level. Prevailing charges may not be higher than 75 percent of the customary charges made for similar items and services in	The update for 2003 is 1.1 percent.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
	products, and transfusion medicine. charge for the item in the locality, (3) the charges made to the carrier's policyholders or subscribers for comparable items, and (4) the inflation-indexed charge. Assignment is optional; balance billing limits do not apply on non-assigned claims. Regular Part B cost-sharing applies.	the locality during the 12-month period of July 1 through June 30 of the previous calendar year. The inflation-indexed charge is updated by the CPI-U.	
11. Ambulatory Surgical Centers (ASCs)			
Medicare Certified Ambulatory Surgical Centers (ASCs)	Medicare uses a fee schedule to pay for the facility services related to a surgery provided in an ASC. The associated physician services (surgery and anesthesia) are paid under the physician fee schedule. CMS maintains the list of approved ASC procedures, which is required to be updated every 2 years. Presently over 2,400 procedures are approved for ASC	The Secretary is required to update ASC rates based on a survey of the actual audited costs incurred by a representative sample of ASCs every 5 years beginning no later than January 1, 1995. Between revisions, the rates are to be updated annually using the CPI-U.	ASCs received an increase of approximately 2 percent for FY2003; payments for each group are rounded up or down to the nearest dollar. The current projection of the CPI-U for FY2004 is 2.0 percent. Effective for services on and after October 1, 2003, the base rates

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	payment and categorized into one of nine payment groups that comprise the ASC facility fee schedule. The nine ASC payment rates reflect the national median cost of procedures in that group; these rates are adjusted to reflect geographic price variation using a hospital wage index. Payments are also adjusted when multiple surgical procedures are performed at the same time. Generally, the ASC will receive full payment for the most expensive procedure and will receive 50 percent payment for the other procedures.	In 1998, CMS proposed a PPS for ASC services. BIPA prohibited implementation of the revised PPS for ASC facility services before January 1, 2002, established a four-year transition period for this PPS system (which was modeled, in part, after the hospital outpatient PPS), and required that ASC rates be rebased using ASC survey data from 1999 or later by January 1, 2003. CMS has not yet implemented these required changes.	(prior to geographic adjustments) are: Payment Group 1.... $340 Payment Group 2.... $455 Payment Group 3.... $520 Payment Group 4.... $643 Payment Group 5.... $731 Payment Group 6.... $840 ($690 + $150 for an intraocular lens) Payment Group 7.... $1,015 Payment Group 8.... $989 ($839 + $150 for an intraocular lens) Payment Group 9.... $1,366

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
12. Hospital Outpatient Services			
Hospital Outpatient Departments (HOPs)	Under HOPD-PPS, which was implemented in August 2000, the unit of payment is the individual service or procedure as assigned to one of about 570 ambulatory payment classifications (APCs). To the extent possible, integral services and items are bundled within each APC, e.g., an APC for a surgical procedure will include operating and recovery room services, anesthesia, and surgical supplies. Specified new technologies are assigned to new technology APCs until clinical and cost data is available to permit assignment into a clinical APC. Medicare's payment for HOPD services is calculated by multiplying the relative weight associated with an APC by a conversion factor. For most APCs, 60 percent of the conversion factor is geographically adjusted by the IPPS wage index. Except for new technology APCs, each APC has a relative weight that	The conversion factor is updated on a calendar year schedule. These annual updates are based on the hospital MB.	For CY2003, the IPPS MB was 3.5 percent. The CY2002 conversion factor of $50.904 was increased by that update and then adjusted to insure that wage index revisions and pass-through payments are budget neutral. The final CY2003 conversion factor is $52.152.

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	is based on the median cost of services in that APC. Certain APCs with significant fluctuations in their relative weights will have the calculated change dampened. The HOPD-PPS also includes budget neutral pass-through payments for new technology and budget neutral outlier payments. Transitional corridor payments (the difference between a HOPDs payments under PPS and payments under the prior reasonable cost reimbursement method) to partially offset hospital losses under HOPD-PPS are available through CY2003. Cancer and children's hospitals have a permanent hold harmless protection from the HOPD-PPS. HOPDs in rural hospitals with 100 or fewer beds have this protection through CY2003. HOPD-PPS also reduces the beneficiary's co-payment for these services. Co-payments will be frozen at 20 percent of the national median charge for the service in		

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
	1996 updated to 1999. Over time, as PPS amounts rise, the frozen beneficiary co-payments will decline as a share of the total payment until the beneficiary share is 20 percent of the Medicare fee schedule amount. A beneficiary copayment amount for a procedure is limited to the inpatient deductible amount established for that year. Balance billing is prohibited.		
13. Rural Health Clinics and Federally Qualified Health Center (FQHCs) Services			
Rural Health Clinics (RHCs) and Federally Qualified Health Center (FQHCs) Services	RHCs and FQHCs are paid on the basis of an all-inclusive rate for each beneficiary visit for covered services. An interim payment is made to the RHC or FQHC based on estimates of allowable costs and number of visits; a reconciliation is made at the end of the year based on actual costs and visits. Per-visit payment limits are established for all RHCs (other than those in hospitals with fewer	Payment limits are updated on January 1 of each year by the Medicare economic index (MEI), which measures inflation for certain medical services. Because of the delay in implementing the MEI, there was one update on January 1, 2003, and a second one on March 1, 2003.	For services provided January 1, 2003 - February 28, 2003, the RHC upper payment limit was $66.46, the urban FQHC limit was $103.18, and the rural FQHC limit was $88.71. For services provided March 1, 2003- December 31, 2003, the RHC upper payment limit is $66.72, the urban FQHC limit is $103.58, and the rural FHQC limit is $89.06.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
	than 50 beds) and FHQCs. Assignment is mandatory; no deductible applies for FHQC services.		
14. Comprehensive Outpatient Rehabilitation Facility (CORF)			
Comprehensive Outpatient Rehabilitation Facility (CORF)	CORFs provide (by or under the supervision of physicians) outpatient diagnostic, therapeutic, and restorative services. Payments for services are made on the basis of the physician fee schedule. Therapy services are subject to the therapy limits (described above for physical and occupational therapy providers).	See physician fee schedule and outpatient physical and occupational therapy services.	See physician fee schedule and outpatient physical and occupational therapy services.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
15. Drugs/Vaccines			
Drugs/Vaccines	Medicare does not cover outpatient prescription drugs or vaccines except for a few specified exceptions (including oral cancer drugs and immunosuppressive drugs following a covered organ transplant). Payment equals 95 percent of the average wholesale price (AWP). (This provision apples except where payment is made on the basis of reasonable costs or prospective payments.) A special limit applies to payments for epoetin (EPO); the limit is $10 per 1,000 units. Regular Part B cost-sharing apples, except for pneumoccal and influenza virus vaccines. Assignment is mandatory.	Beginning in 2003, a single national price is established for each covered drug whose payment allowance is based on 95 percent of the AWP. Effective January 1, 2003, CMS provided single drug pricer (SDP) files to carriers and intermediaries, which specify the price.	No specific provision. The SDP files are expected to be updated several times in 2003.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
16. Blood			
Blood	Medicare pays the reasonable coast for pints of blood, starting with the fourth ping, and blood components that are provided to a hospital outpatient as part of other services. (Blood that is received in an IPPS hospital is bundled in the DRG payment). For IPPS- excluded hospitals, Medicare pays allowable costs for blood. Beneficiary pays for first three pints of blood in a year, after which regular Part B cost-sharing applies.	There is no specific update for the reimbursement of Part B blood costs. The outpatient facility is paid 100 percent of its reasonable costs as reported on its cost reports. See the section on IPPS hospitals for updates for blood included as part of these hospitals.	No specific update.
17. Partial Hospitalization Services Connected to Treatment of Mental Illness			
Partial Hospitalization Servies Connected to Treatment of Mental Illness	Medicare provides Part B hospital outpatient care payments for “partial hospitalization mental health care. The services are covered only if the individual would otherwise require inpatient psychiatric care. Services must be provided under a program which is hospital-based or hospital	See physician fee schedule and hospital outpatient services.	See physician fee schedule and hospital outpatient services.

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	Affiliated and must be a distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care. The program may also be covered when provided in a community mental health center. Payment for professional services is made under the physician fee schedule. Other services are paid under the hospital outpatient prospective payment system. Regular Part B cost-sharing applies; balance billing is prohibited.		
18. Ambulance Services			
Ambulance Services	Medicare pays for ambulance services on the basis of a fee schedule, which is being phased-in over a give-year period (2002-2006). Payment is based on a blend with a gradually increasing portion of the payment based on the fee schedule and a decreasing portion on the former payment methodology (costs or charges).	The fee schedule amount is updated each year by the CPI-U.	The update for 2003 is 1.1 percent.

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	In 2003, the blend is 40 percent of the fee schedule rates and 60 percent of the fee schedule rates and 60 percent of cost or charge rates. In 2006, the payment will be based entirely on the fee schedule. The fee schedule establishes seven categories of ground ambulance services and two categories are: basic life support (BLS), emergency and nonemergency; advanced life support Level 1 (ALS1), both emergency and nonemergency; advanced life support level 2 (ALS2); specialty care transport (SCT); and paramedic ALS intercept (PI). The air ambulance categories are: fixed wing air ambulance (FW) and rotary wing air ambulance (RW). The fee schedule payment for an ambulance service equals a base rate for the level of service plus		

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
	Payment for mileage. Geographic adjustments are made to a portion of the base rate to reflect the relative costs of providing services in various areas of the country. Additionally, the base rate is increased for air ambulance trips originating in rural areas and mileage payments are increased for all trips originating in rural areas. Regular Part B cost-sharing applies. Assignment is mandatory.		

PARTS A AND B

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
1. Home Health			
Home Health	Home health agencies (HHAs) are paid under a prospective payment system that began with FY2001. Oayment is based on 60-day episodes if care for beneficiaries, subject to several adjustments, with unlimited episodes of care in a year. The payment covers skilled nursing, therapy, medical social services, and aide visits and medical supplies. Durable medical equipment is not included in the HH PPS. The base payment amount is adjusted for: (1) differences in area wages using the hospital wage index; (2) differences in the care needs of patients (case mix) using "home health resource groups" (HHRGs); (3) outlier visits (for the extraordinary costly patients); (4) a significant change in a beneficiary's condition (SCIC) when the care needs of a beneficiary increase	The base payment amount, or national standardized 60-day episode rate, is increased annually by an update factor that is determined, in part, by the projected increase in the home health market basket index. This index measures changes in the costs of goods and services purchased by HHAs. The Omnibus Consolidated and Emergency Supplemental Appropriations Act (OCESA) of 1999 and BIPA provide for the following updates: FY2001 = MB FY2002 = MB – 1.1 FY2003 = MB – 1.1 FY2004 and subsequent years = MB	For Fy2004 the update is the full market basket of 3.3 percent. As required by BIPA, payments were increased by 10 percent for HHAs serving rural beneficiaries until March 31, 2003. The temporary rural add-on began April 1, 2001 and continued until March 31, 2003. In addition, as required by BIPA, the so-called 15 percent reduction went in to effect on October 1, 2002. Section 1864(b)(3)(A)(i)(III) of the Social Security Act required that for FY2003, the pre-PPS system of cost limits be reduced by 15 percent and then PPS rates adjusted accordingly, resulting in an actual decrease of 7 percent in the PPS payment rates.

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	Substantially; (5) a partial episode for when a beneficiary transfers from one HHA to another during a 60-day episode; (6) budget neutrality; and (7) a low utilization payment adjustment (LUPA) for beneficiaries who receive four or fewer visits. There is not a distinction between urban and rural base payment amounts. The HHRG applicable to a beneficiary is determined following an assessment of the patient's condition and care needs using the Outcome and Assessment Information Set (OASIS). After the assessment a beneficiary is categorized in one of 80 HHRGs that reflect the beneficiary's clinical severity, functional status, and service requirements. HHAs are paid 60 percent of the case-mix and wage-adjusted payment after submitting a request for anticipated payment (RAP). The		

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
	RAP may be submitted at the beginning of a beneficiary's care once the HHA has received verbal orders from the beneficiary's physician and the assessment is completed. The remaining payment is made when the beneficiary's care is completed or the 60-day episode ends.		
2. Managed Care Organizations			
(a) Cost Contracts	Medicare pays cost contract health maintenance organizations (HMOs) and competitive medical plans (CMPs) the actual costs they incur for furnishing Medicare-covered services (less the estimated value of required Medicare cost-sharing),	No specific update. Cost-based HMOs are paid 100 percent of their actual costs.	No specific update. (However, BBA included provisions to phase-out cost contracts. Since the passage of BBA, the contracts have been extended; currently, the Secretary cannot extend or renew a reasonable cost reimbursement contact for any period beyond December 13, 2004.)

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
	subject to a test of "reasonableness." Interim payment is made to the HMO/CMP on a monthly per capita basis; final payment reconciles interim payments to actual costs.		
(b) Medicare+Choice Contracts	A Medicare+Choice (M+C) plan can be a coordinated care plan (such as an HMO, a preferred provider organization, or a provider sponsored organization), a private fee-for-service plan, or a high deductible plan offered with a M+C medical savings account (although there are no Medicare MSA plans). For each enrolled beneficiary, Medicare pays M+C contractors a prospectively determined monthly capitation payment, which is based on the M+C capitation rate. This rate is set at the highest of one of three amounts, calculated annually for each payment area (generally a county): 1) a blended rate, which is	The M+C rates are recalculated annually y the method described under "General Reimbursement Policy." The national growth percentage is the projected per capita increase in total Medicare expenditures. Initially, when the M+C program was established, adjustments were made to this percentage each year, as follows: 1998 = 0.8 percentage points; 1999 = 0.5 percentage points; 2000 = 0.5 percentage points; 2001 = 0.5 percentage points; 2002 = 0.3 percentage points. After 2002, the national growth percentage is equal to the projected	For 2003, the projected national growth percentage increase is actually a decrease of 2.9 percent. This decrease reflects a 0.9 percent increase in per capita costs and a negative 3.8 percent adjustment for prior years' errors. The –2.9 percent factor is used to update the 2002 blend rate. The 2003 update for the floor is –1 percent, reflecting the same 0.9 percent increase in per capita costs, but only a 1.9 percent decrease for the prior year error in 2002 estimates. Because both of these updates are negative, the minimum percentage increase is the only positive update for 2003, yielding the highest M+C

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
	the sum of 50 percent of the annual area-specific M+C capitation rate for the year for the payment area, and 50 percent of the input-price-adjusted national M+C capitation rate for the year; 2) a minimum payment (or floor) rate; or 3) a minimum percentage increase which is generally 102 percent (BIPA set a higher increase of 103 percent for 2001 only) of the previous year's payment. The area-specific rate used to calculate the blended rate is based on the 1997 rate for the payment area. This amount is reduced to remove a portion of the amount corresponding to Medicare's graduate medical education (GME) payments for the area. The rate is then updated by the projected per capita increase in total Medicare expenditures (the national growth percentage). The national rate is	increase in Medicare per capita expenditures. Furthermore, the national growth percentage is adjusted each year to correct for errors in prior years' rates. For updating the blend, adjustments are made for errors beginning in 1999. For updating the floor, payments, adjustments are only made for errors beginning in 2002, since BIPA resent the floors in 2001.	payment for most counties. The projected national growth percentage increase in 2004 will be 9.5 percent. This increase reflects a 3.7 percent increase in per capita costs and a positive 5.6 percent adjustment for prior years' errors. The 9.5 percent factor is used to update the 2003 blend rate. The 2004 update for the floor is 8.2 percent reflecting the same 3.7 percent increase in per capita costs, but only a 4.3 percent increase for the prior year error estimates. For 2003, all but six counties had their payments set at the minimum update of 2 percent, with the remaining six set at the higher floor payment. For 2004, the floor amounts will be $592 for larger MSAs and $536 for smaller MSAs.

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
	The weighted average of all local area-specific rates. The national rate is adjusted to reflect differences in certain input prices, such as hospital labor costs, by a specified formula. Each year, the percentage of the national rate in the blend was decreased (beginning with 10 percent local and 90 percent national in 1998) and for 2003 and after, the blend is 50 percent local and 50 percent national. Initally, BBA provided for one floor rate that would apply to all counties within the United States. The floor rate is updated annually by the national growth percentage. Beginning March 2001, BIPA established multiple floor rates, based on population and location. For 2003, the floor is $548 for the larger MSAs and $495 for the smaller MSAs.		

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
	Once the preliminary rate is determined for each county, a budget neutrality adjustment is required by law to determine final payment rates. This adjustment is made so that estimated total M+C payments in a given year will be equal to the total payments that would be made if payments were based solely on area-specific rates. A budget neutrality adjustment may only be applied to the blended rates because rates cannot be reduced below the floor or minimum increase amounts. As a result of this limitation, it is not always possible to achieve budget neutrality after all county rates are assigned either the floor or minimum increase. Acutal payments to plans are risk adjusted. By 2004, three different risk adjustment methods will have been used to adjust M+C payment rates: (1) Demographic method		

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
	(through 1999); (2) Principal Inpatient Diagnostic Cost Group (PIP-DCG) which uses hospital inpatient and demographic data (2000-2003); and (3) CMS Hierarchical Condition Category Risk Adjustment Model (CMS-HCC), which uses ambulatory, inpatient, and demographic data (beginning in 2004). In 2003, risk adjustment is based 90 percent on the old demographic method and 10 percent PIP-DCG. In 2004, risk adjustment will be based 70 percent on demographic and 30 percent on CMS-HHC. Organizations which offered a plan in a payment area without a M+C plan since 1997, or in an area where all organizations had announced their withdrawal from the area as of October 13, 1999, received a new entry bonus of 5 percent of the		

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
	Their withdrawal from the area as of October 13, 1999, received from a new entry bonus of 5 percent of the monthly Medicare + Choice payment rate in the first 12 months. BIPA further extended these bonus payments for M+C plans to include areas, for which notification had been provided, as of October 3, 2000, that no plans would be available January 1, 2001. Under current law, no plan will be receiving a bonus after 2003.		
3. End-Stage Renal Disease			
End Stage Renal Disease	Dialysis services are offered in three outpatient settings: hospital-based facilities, independent facilities, and the patient's home. There are two methods for payment. Under Method I, facilities are paid a prospectively set amount, known as the composite rate, for each dialysis	The composite rate is not routinely updated, nor are Method II reasonable charge payments. There is no specific update policy for reasonable costs of kidney acquisition.	BBRA increased the composite rate for services furnished in 2000 by 1.2 percent and an additional 1.2 percent for services furnished on or after January 1, 2001 by 2.4 percent. The maximum composite rate cap (maximum allowed

Provider/Services	General Payment Policy	General Update Policy	Most Recent Update
	session, regardless of whether services are provided at the facility or in the patient's home. The composite rate is derived from audited cost data and adjusted for the national proportion of patients dialyzing at home versus in a facility, and for area wage differences. Adjustments are made to the composite rate for hospital-based dialysis facilities to reflect higher overhead costs. Beneficiaries electing home dialysis may choose not to be associated with a facility and may make independent arrangements with a supplier for equipment, supplies, and support services. Payment to these suppliers, known as Method II, is made on the basis of reasonable charges, limited to 100 percent of the median hospital composite rate, except for patients on continuous cycling peritoneal		payment per treatment) as of January 2002 is $144.59 for urban centers and $144.05 for rural areas.

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	Dialysis when the limit is 130 percent of the median hospital composite rate. Assignment is mandatory; regular Part B cost-sharing applies. Kidney transplantation services, to the extent they are inpatient hospital services, are subject to the PPS. However, kidney acquisition costs are paid on a reasonable cost basis.		

CRS REPORTS FOR ADDITIONAL INFORMATION

RL31419, *Medicare: Payments for Covered Prescription Drugs*, by Jennifer O'Sullivan
RL31199, *Medicare: Payments to Physicians*, by Jennifer O'Sullivan
RL31067 *Medicare Payment System Design: An Overview*, by Carolyn Merck
RL30702, *Medicare+Choice*, by Hinda Ripps Chaikind and Paulette C. Morgan
RL30587, *Medicare+Choice Payments*, by Hinda Ripps Chaikind and Paulette C. Morgan
RL31341, *Medicare's Durable Medical Equipment and Prosthetics and Orthotics, Benefit*, by Heidi G. Yacker
RL21465, *Medicare's Skilled Nursing Facility Payment*, by Jennifer Boulanger